CHAPTER 13
SECTION 3.7

SURGERY

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I. ISSUE

How is surgery to be reimbursed?

II. POLICY

NOTE: The following "Policy" remains in effect until implementation of TRICARE Claimcheck. Upon implementation of TRICARE Claimcheck, and only for claims subject to TRICARE Claimcheck, the appropriate reimbursement methodology will be applied in conjunction with TRICARE Claimcheck auditing guidelines.

A. Multiple Surgery.

1. There is to be no distinction made between "related" and "unrelated" conditions in determining the allowable charge for multiple surgical procedures. When multiple surgical procedures are performed during the same operative session, benefits shall be limited to the lesser of the total billed charge or the sum of 100 percent of the prevailing charge for the major surgical procedure and 50 percent of the prevailing charge for the other procedures. The major procedure is that procedure for which the prevailing charge is greatest.

2. Since providers cannot be expected to bill the various procedures either as a lump sum or consonant with the contractor's prevailing profiles, whenever a contractor receives an itemized claim for multiple surgical procedures, the contractor is to use the sum of the charges in determining reimbursement. Thus, the allowable charge for three surgical procedures would be the lower of the sum of the billed charges or the sum of 100 percent of the prevailing charge for the major procedure and 50 percent of the prevailing charge for each of the other two procedures.

3. When two or more procedures are billed separately but are commonly billed as a single procedure, the allowable charge for the combined single procedure is to be used in determining reimbursement for the claim--even though it may be less than the sum of 100 percent of the prevailing charge for the major procedure and 50 percent of the prevailing charge for the other procedure(s).

4. Where a procedure code is defined to mean a bilateral surgery (e.g., CPT code 27395, lengthening of the hamstring tendon - multiple, bilateral), make no adjustments in the

fee schedule amount that the RVUs for that code yield. However, where the procedure code is not defined to mean a bilateral surgery and a bilateral procedure was performed by the same surgeon, on the same patient, and on the same day, reimburse at 1-1/2 times the unilateral profile which will be 150 percent of the fee schedule amount. A bilateral procedure is treated as a multiple surgical procedure consisting of a primary and secondary procedure. Multiple bilateral procedures, when billed together, should follow the multiple surgery rules allowing 100 percent of the prevailing charge for the major surgical procedure and 50 percent of the prevailing charge for the other procedures.

EXAMPLE: Three bilateral surgical procedures performed at the same surgical session.

PROCEDURE	ALLOWABLE CHARGE	AMOUNT ALLOWED
1	$300	$300
1	$300	$150
2	$100	$50
2	$100	$50
3	$50	$25
3	$50	$25

5. Exceptions to the above policy are:

a. If the multiple surgical procedures involve the fingers or toes, benefits for the third and subsequent procedures are to be limited to 25 percent of the prevailing charge.

b. Incidental procedures.

(1) No reimbursement is to be made for an incidental procedure. Incidental procedures are those identified by TRICARE Claimcheck. For specific instructions regarding incidental procedures identified by TRICARE Claimcheck, see Chapter 11, Section 14.1.

(2) A procedure is determined to be incidental because it is clinically integral to the performance of the primary procedure, and it requires so little time and effort in addition to the primary procedure that no separate payment is made for it. Payment for the incidental procedure is considered to be included in the payment of a paid service (the primary procedure), and, as such, it is an allowable charge reduction. This means that a participating provider must accept the allowable amount for the primary procedure as payment in full for both procedures, and, under the balance billing limitation, a non-participating provider can bill the beneficiary only 115 percent of the allowable amount for the primary procedure and this covers both procedures. (See Chapter 13, Section 1.5, paragraph II.G.2.)

6. Data which is distorted because of these multiple surgery procedures (e.g., where the sum of the charges is applied to the single major procedure) must not be entered into the data base used to develop allowable charge profiles.

B. Multiple Primary Surgeons. When more than one surgeon acts as a primary surgeon for multiple procedures during the same operative session, the services of each may be covered, subject to the following considerations:

1. For cosurgeons (modifier 62), TRICARE pays 125% of the global fee and divides the payment equally between the two surgeons. This means that each surgeon receives 62.5 percent of the TRICARE allowable charge for each procedure. No payment may be made for an assistant surgeon in such cases.

2. For team surgery (modifier 66), payment needs to be determined on a case-by-case basis. Team surgery cases may be seen with organ transplants, separation of siamese twins, severe trauma cases, and cases of a similar nature.

3. The limitations in paragraph II.A.5.a. and paragraph II.A.5.b. above would still apply.

4. All claims for multiple primary surgeons require medical review by the contractor.

5. Payment may not be made to any of the primary surgeons for assisting any of the other primary surgeons.

C. Assistant Surgeons. See Chapter 13, Section 3.7A.

D. Pre-operative care. Pre-operative care rendered in a hospital when the admission is expressly for the surgery is normally included in the global surgery charge. If it is itemized, the contractor must total the charges in order to determine the allowable charge. The admitting history and physical is included in the global package. This also applies to routine examinations in the surgeon's office where such examination is performed to assess the beneficiary's suitability for the subsequent surgery.

E. Post-operative care. All services provided by the surgeon for post-operative complications (e.g., replacing stitches, servicing infected wounds) are included in the global package if they do not require additional trips to the operating room. All visits with the primary surgeon during the 90-day period following major surgery are included in the global package. Relative value studies often specify the number of days during which routine follow-up care can be expected. If a physician itemizes the surgery charge and the charges for routine post-operative care, the contractor shall use the total of the charges as a single charge from which the allowable charge is determined.

NOTE: This rule does not apply if the visit is for a problem unrelated to the diagnosis for which the surgery was performed or is for an added course of treatment other than the normal recovery from surgery. For example, if after surgery for cancer, the physician who performed the surgery subsequently administers chemotherapy services, these services are not part of the global surgery package.

F. Re-operations for complications. All medically necessary return trips to the operating room, for any reason and without regard to fault, are paid for separately, but at a reduced rate. The payment level for re-operations to deal with complications is set at the value of the global surgery code being performed, if there is a CPT code for the re-operation services.

There are several codes describing re-operations necessitated by complications for various body areas. If no separate code exists, however, payment is limited to 50% of the value of the global service originally performed.

G. Global surgery for major surgical procedures. Physicians who perform the entire global package which includes the surgery and the pre- and post-operative care should bill for their services with the appropriate CPT code only. Do not bill separately for visits or other services included in this global package.

1. The surgery code with a -54 or -55 modifier will be reimbursed as a percentage of the total global fee. This percentage will differ depending on the procedure. The percentage for major surgeries include:

PROCEDURE CODE	MODIFIER 54 PERCENTAGE	MODIFIER 55 PERCENTAGE
10000-19499	81%	19%
20000-29909	79%	21%
30000-32999	86%	14%
33010-37799	93%	7%
38100-38999	84%	16%
39000-39599	93%	7%
40490-49999	90%	10%
50010-53899	91%	9%
54000-55980	90%	10%
56000-58999	86%	14%
59000-59899	77%	23%
60000-60699	91%	9%
61000-64999	87%	13%
65091-68899	80%	20%
69000-69979	86%	14%
92986-92990	93%	7%

NOTE: Modifier 54 = pre and interoperative surgery
Modifier 55 = post operative surgery

2. The global period for a major surgery includes the day of surgery. The pre-operative period is the first day immediately before the day of surgery. The post-operative period is the 90 days immediately following the day of surgery. If the patient is returned to surgery for complications on another day, the post-operative period is 90 days immediately after the last operation.

H. Second opinion.

1. Claims for patient-initiated, second-physician opinions pertaining to the medical need for surgery may be paid. Payment may be made for the history and examination of the patient as well as any other covered diagnostic services required in order for the physician to properly evaluate the patient's condition and render a professional opinion on the medical need for surgery.

2. In the event that the recommendations of the first and second physician differ regarding the medical need for such surgery, a claim for a patient-initiated opinion from a third physician is also reimbursable. Such claims are payable even though the beneficiary has the surgery performed against the recommendation of the second (or third) physician.

3. Payments for patient-initiated, second (or third) opinions will be based on the reasonable charges for consultations (and related services) of a comparable level of care.

I. In-office surgery. Charges for a surgical suite in an individual professional provider's office, including charges for services rendered by other than the individual professional provider performing the surgery and items directly related to the use of the surgical suite, may not be cost-shared unless the suite is a TRICARE-approved ambulatory surgery center.

III. EFFECTIVE DATE

The revisions to the procedures for reimbursing multiple surgical procedures (i.e., the elimination of the distinction between related and unrelated procedures) are effective for claims processed on or after August 5, 1988.

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